Reprinted
February 27, 2008

ENGROSSED
SENATE BILL No. 315

DIGEST OF SB 315 (Updated February 26, 2008 4:43 pm - DI 77)

Citations Affected: IC 12-7; IC 12-9; IC 12-10; noncode.

Synopsis: Aging and long term care services. Provides that a person who has made certain asset transfers is not eligible for residential care assistance. Transfers the adult guardianship program from the division of aging to the division of disability and rehabilitative services. Requires rules to be adopted to: (1) implement a screening and counseling program for individuals seeking long term care services; (2) implement a process of prior approval for certain individuals seeking admission to a nursing facility; and (3) the annual review of Medicaid rates. Prohibits the state department of health from approving the certification of new or converted comprehensive care beds for participation in the Medicaid program until July 1, 2011, unless the state comprehensive care bed occupancy rate is more than 95% in health facilities. Allows for an exception for replacement beds if specified requirements are met. Makes conforming and technical changes.

Effective: March 31, 2008; July 1, 2008.

Dillon, Hume, Mrvan, Deig
(HOUSE SPONSORS — HOY, CROUCH)

January 10, 2008, read first time and referred to Committee on Health and Provider Services.
January 17, 2008, reported favorably — Do Pass; reassigned to Committee on Appropriations.
January 24, 2008, amended, reported favorably — Do Pass.
January 28, 2008, read second time, amended, ordered engrossed.
January 29, 2008, engrossed. Read third time, passed. Yeas 48, nays 0.

HOUSE ACTION

February 4, 2008, read first time and referred to Committee on Public Health.
February 21, 2008, amended, reported — Do Pass.
February 26, 2008, read second time, amended, ordered engrossed.

Reprinted
February 27, 2008

Second Regular Session 115th General Assembly (2008)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 2007 Regular Session of the General Assembly.

ENGROSSED
SENATE BILL No. 315

A BILL FOR AN ACT to amend the Indiana Code concerning human services.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 12-7-2-114 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2008]: Sec. 114. "Incapacitated individual", for purposes of ~~IC 12-10-7,~~ **IC 12-9-7,** has the meaning set forth in ~~IC 12-10-7-1.~~ **IC 12-9-7-1.**

SECTION 2. IC 12-7-2-116 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2008]: Sec. 116. "Indigent adult", for purposes of ~~IC 12-10-7,~~ **IC 12-9-7,** has the meaning set forth in ~~IC 12-10-7-2.~~ **IC 12-9-7-2.**

SECTION 3. IC 12-7-2-149.1, AS AMENDED BY P.L.145-2006, SECTION 57, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2008]: Sec. 149.1. "Provider" means the following:

(1) For purposes of ~~IC 12-10-7,~~ **IC 12-9-7,** the meaning set forth in ~~IC 12-10-7-3.~~ **IC 12-9-7-3.**

(2) For purposes of the following statutes, an individual, a partnership, a corporation, or a governmental entity that is enrolled in the Medicaid program under rules adopted under IC 4-22-2 by the office of Medicaid policy and planning:

(A) IC 12-14-1 through IC 12-14-9.5.

(B) IC 12-15, except IC 12-15-32, IC 12-15-33, and IC 12-15-34.

(C) IC 12-17.6.

(3) Except as provided in subdivision (4), for purposes of IC 12-17.2, a person who operates a child care center or child care home under IC 12-17.2.

(4) For purposes of IC 12-17.2-3.5, a person that:

(A) provides child care; and

(B) is directly paid for the provision of the child care under the federal Child Care and Development Fund voucher program administered under 45 CFR 98 and 45 CFR 99.

The term does not include an individual who provides services to a person described in clauses (A) and (B), regardless of whether the individual receives compensation.

SECTION 4. IC 12-7-2-159 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2008]: Sec. 159. "Region", for purposes of ~~IC 12-10-7,~~ **IC 12-9-7,** has the meaning set forth in ~~IC 12-10-7-4.~~ **IC 12-9-7-4.**

SECTION 5. IC 12-9-7 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2008]:

Chapter 7. Adult Guardianship Services

Sec. 1. As used in this chapter, "incapacitated individual" means an individual who:

(1) cannot be located upon reasonable inquiry;

(2) is unable:

(A) to manage in whole or in part the individual's property;

(B) to provide self-care; or

(C) to do either of the functions described in clauses (A) and (B);

because of mental illness, dementia, physical illness, infirmity, habitual drunkenness, excessive use of drugs, confinement, detention, duress, fraud, undue influence of others on the individual, or other disability (as that term is used in IC 12-10-10-3 or IC 12-14-15-1); or

(3) has a developmental disability.

Sec. 2. As used in this chapter, "indigent adult" means an individual who:

(1) is at least eighteen (18) years of age;

(2) has no appropriate person to serve as guardian; and

(3) either:

(A) has an annual gross income of not more than one hundred twenty-five percent (125%) of the federal income poverty level as determined annually by the federal Office of Management and Budget under 42 U.S.C. 9902; or

(B) demonstrates the inability to obtain privately provided guardianship services.

Sec. 3. As used in this chapter, "provider" refers to a regional guardianship services provider.

Sec. 4. As used in this chapter, "region" means a service provision region established by the division by rule adopted under IC 4-22-2.

Sec. 5. The adult guardianship services program is established to provide services within the limits of available funding for indigent incapacitated adults.

Sec. 6. The director shall administer the program on a statewide basis.

Sec. 7. The director of the division shall adopt rules under IC 4-22-2 to implement this chapter.

Sec. 8. (a) The division shall contract in writing for the provision of the guardianship services required in each region with a nonprofit corporation that is:

(1) qualified to receive tax deductible contributions under Section 170 of the Internal Revenue Code; and

(2) located in the region.

(b) The division shall establish qualifications to determine eligible providers in each region.

(c) Each contract between the division and a provider must specify a method for the following:

(1) The establishment of a guardianship committee within the provider, serving under the provider's board of directors.

(2) The provision of money and services by the provider in an amount equal to at least twenty-five percent (25%) of the total amount of the contract and the provision by the division of the remaining amount of the contract. The division shall establish guidelines to determine the value of services provided under this subdivision.

(3) The establishment of procedures to avoid a conflict of interest for the provider in providing necessary services to each incapacitated individual.

(4) The identification and evaluation of indigent adults in need of guardianship services.

(5) The adoption of individualized service plans to provide the least restrictive type of guardianship or related services for each incapacitated individual, including the following:

(A) Designation as a representative payee by:

(i) the Social Security Administration;

(ii) the United States Office of Personnel Management;

(iii) the United States Department of Veterans Affairs; or

(iv) the United States Railroad Retirement Board.

(B) Limited guardianship under IC 29-3.

(C) Guardianship of the person or estate under IC 29-3.

(D) The appointment of:

(i) a health care representative under IC 16-36-1-7; or

(ii) a power of attorney under IC 30-5.

(6) The periodic reassessment of each incapacitated individual.

(7) The provision of legal services necessary for the guardianship.

(8) The training and supervision of paid and volunteer staff.

(9) The establishment of other procedures and programs required by the division.

Sec. 9. (a) Each provider is subject to periodic audit of the adult guardianship services program by an independent certified public accountant.

(b) The results of the audit required under subsection (a) must be submitted to the division.

SECTION 6. IC 12-10-6-2.1, AS AMENDED BY P.L.99-2007, SECTION 61, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2008]: Sec. 2.1. (a) An individual who is incapable of residing in the individual's own home may apply for residential care assistance under this section. The determination of eligibility for residential care assistance is the responsibility of the division. Except as provided in subsections (g) and (i), an individual is eligible for residential care assistance if the division determines that the individual:

(1) is a recipient of Medicaid or the federal Supplemental Security Income program;

(2) is incapable of residing in the individual's own home because of dementia, mental illness, or a physical disability;

(3) requires a degree of care less than that provided by a health care facility licensed under IC 16-28; ~~and~~

(4) can be adequately cared for in a residential care setting; **and**

(5) has not made any asset transfer prohibited under the state plan or in 42 U.S.C. 1396p(c) in order to be eligible for

Medicaid.

(b) Individuals with mental retardation may not be admitted to a home or facility that provides residential care under this section.

(c) A service coordinator employed by the division may:

(1) evaluate a person seeking admission to a home or facility under subsection (a); or

(2) evaluate a person who has been admitted to a home or facility under subsection (a), including a review of the existing evaluations in the person's record at the home or facility.

If the service coordinator determines the person evaluated under this subsection has mental retardation, the service coordinator may recommend an alternative placement for the person.

(d) Except as provided in section 5 of this chapter, residential care consists of only room, board, and laundry, along with minimal administrative direction. State financial assistance may be provided for such care in a boarding or residential home of the applicant's choosing that is licensed under IC 16-28 or a Christian Science facility listed and certified by the Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc., that meets certain life safety standards considered necessary by the state fire marshal. Payment for such care shall be made to the provider of the care according to division directives and supervision. The amount of nonmedical assistance to be paid on behalf of a recipient living in a boarding home, residential home, or Christian Science facility shall be based on the daily rate established by the division. The rate for facilities that are referred to in this section and licensed under IC 16-28 may not exceed an upper rate limit established by a rule adopted by the division. The recipient may retain from the recipient's income a monthly personal allowance of fifty-two dollars ($52). This amount is exempt from income eligibility consideration by the division and may be exclusively used by the recipient for the recipient's personal needs. However, if the recipient's income is less than the amount of the personal allowance, the division shall pay to the recipient the difference between the amount of the personal allowance and the recipient's income. A reserve or an accumulated balance from such a source, together with other sources, may not be allowed to exceed the state's resource allowance allowed for adults eligible for state supplemental assistance or Medicaid as established by the rules of the office of Medicaid policy and planning.

(e) In addition to the amount that may be retained as a personal allowance under this section, an individual shall be allowed to retain an amount equal to the individual's state and local income tax liability.

The amount that may be retained during a month may not exceed one-third (1/3) of the individual's state and local income tax liability for the calendar quarter in which that month occurs. This amount is exempt from income eligibility consideration by the division. The amount retained shall be used by the individual to pay any state or local income taxes owed.

(f) In addition to the amounts that may be retained under subsections (d) and (e), an eligible individual may retain a Holocaust victim's settlement payment. The payment is exempt from income eligibility consideration by the division.

(g) The rate of payment to the provider shall be determined in accordance with a prospective prenegotiated payment rate predicated on a reasonable cost related basis, with a growth of profit factor, as determined in accordance with generally accepted accounting principles and methods, and written standards and criteria, as established by the division. The division shall establish an administrative appeal procedure to be followed if rate disagreement occurs if the provider can demonstrate to the division the necessity of costs in excess of the allowed or authorized fee for the specific boarding or residential home. The amount may not exceed the maximum established under subsection (d).

(h) The personal allowance for one (1) month for an individual described in subsection (a) is the amount that an individual would be entitled to retain under subsection (d) plus an amount equal to one-half (1/2) of the remainder of:

(1) gross earned income for that month; minus

(2) the sum of:

(A) sixteen dollars ($16); plus

(B) the amount withheld from the person's paycheck for that month for payment of state income tax, federal income tax, and the tax prescribed by the federal Insurance Contribution Act (26 U.S.C. 3101 et seq.); plus

(C) transportation expenses for that month; plus

(D) any mandatory expenses required by the employer as a condition of employment.

(i) An individual who, before September 1, 1983, has been admitted to a home or facility that provides residential care under this section is eligible for residential care in the home or facility.

(j) The director of the division may contract with the division of mental health and addiction or the division of disability and rehabilitative services to purchase services for individuals with a mental illness or a developmental disability by providing money to

supplement the appropriation for community residential care programs established under IC 12-22-2 or community residential programs established under IC 12-11-1.1-1.

(k) A person with a mental illness may not be placed in a Christian Science facility listed and certified by the Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc., unless the facility is licensed under IC 16-28.

SECTION 7. IC 12-10-6-3, AS AMENDED BY P.L.1-2007, SECTION 117, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2008]: Sec. 3. (a) The division, in cooperation with the state department of health, taking into account licensure requirements under IC 16-28, shall adopt rules under IC 4-22-2 governing the reimbursement to facilities under section 2.1 of this chapter. The rules must be designed to determine the costs that must be incurred by efficiently and economically operated facilities in order to provide room, board, laundry, and other services, along with minimal administrative direction to individuals who receive residential care in the facilities under section 2.1 of this chapter.

(b) A rule adopted under ~~this~~ subsection **(a)** by:

(1) the division; or

(2) the state department of health;

must conform to the rules for residential care facilities that are licensed under IC 16-28.

~~(b)~~ **(c)** Any rate established under section 2.1 of this chapter may be appealed according to the procedures under IC 4-21.5.

~~(c)~~ **(d)** The division shall annually review each facility's rate using the following:

(1) Generally accepted accounting principles.

(2) The costs incurred by efficiently and economically operated facilities in order to provide care and services in conformity with quality and safety standards and applicable laws and rules.

SECTION 8. IC 12-10-12-6, AS AMENDED BY P.L.50-2007, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2008]: Sec. 6. (a) This subsection does not apply after ~~June 30, 2008.~~ **December 30, 2008.** If an individual who is discharged from a hospital licensed under IC 16-21:

(1) is admitted to a nursing facility after the individual has been screened under the nursing facility preadmission program described in this chapter; and

(2) is eligible for participation in the federal Medicaid program;

prior approval of the individual's admission to the nursing facility may not be required by the office under IC 12-15-21-1 through

IC 12-15-21-3.

(b) This subsection applies beginning ~~July 1, 2008.~~ **December 31, 2008.** If an individual:

(1) is admitted to a nursing facility after the individual has been screened under the nursing facility preadmission program described in this chapter; and

(2) is eligible for participation in the federal Medicaid program;

prior approval of the individual's admission to the nursing facility may be required by the office under IC 12-15-21-1 through IC 12-15-21-3.

(c) The office ~~may~~ **shall** adopt rules under IC 4-22-2 to implement:

(1) subsection (b);

(2) a screening and counseling program for individuals seeking long term care services; and

(3) a biennial review of Medicaid waiver reimbursement rates.

~~However, the adopted rules may not take effect before July 1, 2008.~~

SECTION 9. IC 12-10-12-16 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2008]: Sec. 16. (a) A screening team shall conduct a nursing facility preadmission screening program for each individual within the time permitted under this chapter. The program must consist of an assessment of the following:

(1) The individual's medical needs.

(2) The availability of services, other than services provided in a nursing facility, that are appropriate to the individual's needs.

(3) The cost effectiveness of providing services appropriate to the individual's needs that are provided outside of, rather than within, a nursing facility.

(b) The assessment must be conducted in accordance with rules adopted under IC 4-22-2 by the director of the division in cooperation with the office.

(c) Communication among members of a screening team or between a screening team and the division, ~~or~~ the office, **or the agency** during the prescreening process may be conducted ~~using~~ **by means including** any of the following:

(1) Standard mail.

(2) Express mail.

(3) Facsimile machine.

(4) Secured electronic communication.

SECTION 10. IC 12-10-7 IS REPEALED [EFFECTIVE JULY 1, 2008].

SECTION 11. [EFFECTIVE JULY 1, 2008] **(a) On July 1, 2008, all rules, contracts, assets, and liabilities of the division of aging's**

guardianship program under IC 12-10-7 (before its repeal by this act) are transferred to the division of disability and rehabilitative services under IC 12-9-7 (as added by this act) and are considered rules, contracts, assets, and liabilities of the division of disability and rehabilitative services.

(b) This SECTION expires July 1, 2013.

SECTION 12. [EFFECTIVE MARCH 31, 2008] **(a) This SECTION does not apply to the conversion of acute care beds to comprehensive care beds pursuant to IC 16-29-3.**

(b) As used in this SECTION, "comprehensive care bed" means a bed that:

(1) is licensed or is to be licensed under IC 16-28-2;

(2) functions as a bed licensed under IC 16-28-2; or

(3) is subject to IC 16-28.

The term does not include a comprehensive care bed that will be used solely to provide specialized services and that is subject to IC 16-29.

(c) As used in this SECTION, "replacement bed" means a comprehensive care bed that is relocated to a health facility that is licensed or is to be licensed under IC 16-28. This term includes comprehensive care beds that are certified for participation in:

(1) the state Medicaid program; or

(2) both the state Medicaid program and federal Medicare program.

(d) Except as provided in subsection (e), the Indiana health facilities council may not recommend and the state department of health may not approve the certification of new or converted comprehensive care beds for participation in the state Medicaid program unless the statewide comprehensive care bed occupancy rate is more than ninety-five percent (95%), as calculated annually on January 1 by the state department of health.

(e) This SECTION does not apply to a health facility that:

(1) seeks a replacement bed exception under subsection (d);

(2) is licensed or is to be licensed under IC 16-28;

(3) applies to the state department of health to certify a comprehensive care bed for participation in the Medicaid program if the comprehensive care bed for which the health facility is seeking certification is a replacement bed for an existing comprehensive care bed;

(4) applies to the division of aging in the manner:

(A) described in subsection (e); and

(B) prescribed by the division; and

(5) meets the licensure, survey, and certification requirements of IC 16-28.

(f) An application described in subsection (e)(4) for a replacement bed exception must include the following:

(1) The total number and identification of the existing comprehensive care beds that the applicant requests be replaced by health facility location and by provider.

(2) If the replacement bed is being transferred to a different health facility, a verification from the health facility holding the comprehensive care bed certification that the health facility has agreed to transfer the beds to the applicant health facility.

(3) If the replacement bed is being transferred to a different health facility under different ownership, a copy of the complete agreement between the health facility transferring the beds and the applicant health facility.

(4) Any other information requested by the division of aging that is necessary to evaluate the transaction.

(g) This SECTION expires June 30, 2011.

SECTION 13. **An emergency is declared for this act.**

COMMITTEE REPORT

Madam President: The Senate Committee on Health and Provider Services, to which was referred Senate Bill No. 315, has had the same under consideration and begs leave to report the same back to the Senate with the recommendation that said bill DO PASS and be reassigned to the Senate Committee on Appropriations.

(Reference is made to Senate Bill 315 as introduced.)

MILLER, Chairperson

Committee Vote: Yeas 11, Nays 0.

SENATE MOTION

Madam President: I move that Senators Hume, Mrvan and Deig be added as coauthors of Senate Bill 315.

DILLON

COMMITTEE REPORT

Madam President: The Senate Committee on Appropriations, to which was referred Senate Bill No. 315, has had the same under consideration and begs leave to report the same back to the Senate with the recommendation that said bill be AMENDED as follows:

Page 1, delete lines 1 through 17.

Delete page 2.

Page 3, delete lines 1 through 5.

Page 3, line 8, reset in roman "(a) This subsection does not apply after".

Page 3, line 9, after "2008." insert "**December 30, 2008.**".

Page 3, line 11, reset in roman "nursing".

Page 3, line 11, delete "health".

Page 3, line 12, reset in roman "nursing facility preadmission".

Page 3, line 12, delete "long term".

Page 3, line 13, delete "care screening and counseling".

Page 3, line 16, reset in roman "nursing".

Page 3, line 16, delete "health".

Page 3, line 19, reset in roman "(b) This subsection applies beginning".

Page 3, line 19, after "2008." insert "**December 31, 2008.**".

Page 3, line 19, reset in roman "If an individual:".

Page 3, reset in roman lines 20 through 25.

Page 3, line 26, reset in roman "(c) The office".

Page 3, line 26, after "may" insert "**shall**".

Page 3, line 26, reset in roman "adopt rules under IC 4-22-2 to implement".

Page 3, line 26, after "implement" insert ":

(1)".

Page 3, line 27, reset in roman "subsection (b)".

Page 3, line 27, after "(b)" delete "." and insert "; **and**

(2) a screening and counseling program for individuals seeking long term care services.".

Page 3, delete lines 29 through 42.

Delete page 4.

Page 5, delete lines 1 through 32.

Page 5, line 34, delete "and".

Page 5, line 35, delete "counseling".

Page 5, line 35, reset in roman "a nursing facility preadmission".

Page 5, line 36, reset in roman "screening".

Page 5, line 36, delete "the long term care screening and counseling".

Page 5, line 37, reset in roman "The".

Page 5, reset in roman lines 38 through 42.

Page 6, reset in roman lines 1 through 2.

Page 6, line 6, delete "and counseling".

Page 6, line 7, delete "and counseling".

Page 6, line 7, delete "division, or" and insert "**division or**".

Page 6, line 8, delete ", or the agency".

Page 6, line 8, reset in roman "prescreening".

Page 6, delete lines 14 through 42.

Delete pages 7 through 11.

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to SB 315 as introduced.)

MEEKS, Chairperson

Committee Vote: Yeas 11, Nays 0.

SENATE MOTION

Madam President: I move that Senate Bill 315 be amended to read as follows:

Page 2, line 24, delete "or" and insert "**,**".

Page 2, line 24, after "office" insert "**, or the agency**".

Page 2, line 25, after "conducted" strike "using" and insert "**by means including**".

(Reference is to SB 315 as printed January 25, 2008.)

DILLON

COMMITTEE REPORT

Mr. Speaker: Your Committee on Public Health, to which was referred Senate Bill 315, has had the same under consideration and begs leave to report the same back to the House with the recommendation that said bill be amended as follows:

Page 1, between the enacting clause and line 1, begin a new paragraph and insert:

"SECTION 1. IC 12-7-2-114 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2008]: Sec. 114. "Incapacitated individual", for purposes of ~~IC 12-10-7,~~ **IC 12-9-7,** has the meaning set forth in ~~IC 12-10-7-1.~~ **IC 12-9-7-1.**

SECTION 2. IC 12-7-2-116 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2008]: Sec. 116. "Indigent adult", for purposes of ~~IC 12-10-7,~~ **IC 12-9-7,** has the meaning set forth in ~~IC 12-10-7-2.~~ **IC 12-9-7-2.**

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(1) For purposes of ~~IC 12-10-7,~~ **IC 12-9-7,** the meaning set forth in ~~IC 12-10-7-3.~~ **IC 12-9-7-3.**

(2) For purposes of the following statutes, an individual, a partnership, a corporation, or a governmental entity that is enrolled in the Medicaid program under rules adopted under IC 4-22-2 by the office of Medicaid policy and planning:

(A) IC 12-14-1 through IC 12-14-9.5.

(B) IC 12-15, except IC 12-15-32, IC 12-15-33, and IC 12-15-34.

(C) IC 12-17.6.

(3) Except as provided in subdivision (4), for purposes of IC 12-17.2, a person who operates a child care center or child care home under IC 12-17.2.

(4) For purposes of IC 12-17.2-3.5, a person that:

(A) provides child care; and

(B) is directly paid for the provision of the child care under the federal Child Care and Development Fund voucher program administered under 45 CFR 98 and 45 CFR 99.

The term does not include an individual who provides services to a person described in clauses (A) and (B), regardless of whether the individual receives compensation.

SECTION 4. IC 12-7-2-159 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2008]: Sec. 159. "Region", for purposes of ~~IC 12-10-7,~~ **IC 12-9-7,** has the meaning set forth in ~~IC 12-10-7-4.~~ **IC 12-9-7-4.**

SECTION 5. IC 12-9-7 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2008]:

Chapter 7. Adult Guardianship Services

Sec. 1. As used in this chapter, "incapacitated individual" means an individual who:

(1) cannot be located upon reasonable inquiry;

(2) is unable:

(A) to manage in whole or in part the individual's property;

(B) to provide self-care; or

(C) to do either of the functions described in clauses (A) and (B);

because of mental illness, dementia, physical illness, infirmity, habitual drunkenness, excessive use of drugs, confinement, detention, duress, fraud, undue influence of others on the individual, or other disability (as that term is used in IC 12-10-10-3 or IC 12-14-15-1); or

(3) has a developmental disability.

Sec. 2. As used in this chapter, "indigent adult" means an individual who:

(1) is at least eighteen (18) years of age;

(2) has no appropriate person to serve as guardian; and

(3) either:

(A) has an annual gross income of not more than one hundred twenty-five percent (125%) of the federal income poverty level as determined annually by the federal Office

of Management and Budget under 42 U.S.C. 9902; or

(B) demonstrates the inability to obtain privately provided guardianship services.

Sec. 3. As used in this chapter, "provider" refers to a regional guardianship services provider.

Sec. 4. As used in this chapter, "region" means a service provision region established by the division by rule adopted under IC 4-22-2.

Sec. 5. The adult guardianship services program is established to provide services within the limits of available funding for indigent incapacitated adults.

Sec. 6. The director shall administer the program on a statewide basis.

Sec. 7. The director of the division shall adopt rules under IC 4-22-2 to implement this chapter.

Sec. 8. (a) The division shall contract in writing for the provision of the guardianship services required in each region with a nonprofit corporation that is:

(1) qualified to receive tax deductible contributions under Section 170 of the Internal Revenue Code; and

(2) located in the region.

(b) The division shall establish qualifications to determine eligible providers in each region.

(c) Each contract between the division and a provider must specify a method for the following:

(1) The establishment of a guardianship committee within the provider, serving under the provider's board of directors.

(2) The provision of money and services by the provider in an amount equal to at least twenty-five percent (25%) of the total amount of the contract and the provision by the division of the remaining amount of the contract. The division shall establish guidelines to determine the value of services provided under this subdivision.

(3) The establishment of procedures to avoid a conflict of interest for the provider in providing necessary services to each incapacitated individual.

(4) The identification and evaluation of indigent adults in need of guardianship services.

(5) The adoption of individualized service plans to provide the least restrictive type of guardianship or related services for each incapacitated individual, including the following:

(A) Designation as a representative payee by:

(i) the Social Security Administration;

(ii) the United States Office of Personnel Management;

(iii) the United States Department of Veterans Affairs; or

(iv) the United States Railroad Retirement Board.

(B) Limited guardianship under IC 29-3.

(C) Guardianship of the person or estate under IC 29-3.

(D) The appointment of:

(i) a health care representative under IC 16-36-1-7; or

(ii) a power of attorney under IC 30-5.

(6) The periodic reassessment of each incapacitated individual.

(7) The provision of legal services necessary for the guardianship.

(8) The training and supervision of paid and volunteer staff.

(9) The establishment of other procedures and programs required by the division.

Sec. 9. (a) Each provider is subject to periodic audit of the adult guardianship services program by an independent certified public accountant.

(b) The results of the audit required under subsection (a) must be submitted to the division.

SECTION 6. IC 12-10-1-3, AS AMENDED BY P.L.99-2007, SECTION 59, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2008]: Sec. 3. The bureau shall administer the following programs:

(1) The federal Older Americans Act under IC 12-9.1-4-1.

(2) Area agencies on aging services under this article.

(3) Adult protective services under IC 12-10-3.

(4) Room and board assistance and assistance to residents in county homes under IC 12-10-6.

(5) Adult guardianship program under IC ~~12-10-7.~~ **IC 12-9-7.**

(6) Community and home options for the elderly and individuals with a disability under IC 12-10-10.

(7) Nursing home preadmission screening under IC 12-10-12.

(8) Long term care advocacy under IC 12-10-13.

(9) Nutrition services and home delivered meals.

(10) Title III B supportive services.

(11) Title III D in-home services.

(12) Aging programs under the Social Services Block Grant.

(13) United States Department of Agriculture elderly feeding program.

(14) Title V senior employment.

(15) PASARR under older adult services.

SECTION 7. IC 12-10-6-2.1, AS AMENDED BY P.L.99-2007, SECTION 61, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2008]: Sec. 2.1. (a) An individual who is incapable of residing in the individual's own home may apply for residential care assistance under this section. The determination of eligibility for residential care assistance is the responsibility of the division. Except as provided in subsections (g) and (i), an individual is eligible for residential care assistance if the division determines that the individual:

(1) is a recipient of Medicaid or the federal Supplemental Security Income program;

(2) is incapable of residing in the individual's own home because of dementia, mental illness, or a physical disability;

(3) requires a degree of care less than that provided by a health care facility licensed under IC 16-28; ~~and~~

(4) can be adequately cared for in a residential care setting; **and**

(5) has not made any asset transfer prohibited under the state plan or in 42 U.S.C. 1396p(c) in order to be eligible for Medicaid.

(b) Individuals with mental retardation may not be admitted to a home or facility that provides residential care under this section.

(c) A service coordinator employed by the division may:

(1) evaluate a person seeking admission to a home or facility under subsection (a); or

(2) evaluate a person who has been admitted to a home or facility under subsection (a), including a review of the existing evaluations in the person's record at the home or facility.

If the service coordinator determines the person evaluated under this subsection has mental retardation, the service coordinator may recommend an alternative placement for the person.

(d) Except as provided in section 5 of this chapter, residential care consists of only room, board, and laundry, along with minimal administrative direction. State financial assistance may be provided for such care in a boarding or residential home of the applicant's choosing that is licensed under **IC 12-22-2,** IC 16-28, or a Christian Science facility listed and certified by the Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc., that meets certain life safety standards considered necessary by the state fire marshal. Payment for such care shall be made to the provider of the care according to division directives and supervision. The amount of nonmedical assistance to be paid on behalf of a recipient living in a boarding home, residential home, or Christian Science facility shall be

based on the daily rate established by the division. The rate for facilities that are referred to in this section and licensed under IC 16-28 may not exceed an upper rate limit established by a rule adopted by the division. The recipient may retain from the recipient's income a monthly personal allowance of fifty-two dollars ($52). This amount is exempt from income eligibility consideration by the division and may be exclusively used by the recipient for the recipient's personal needs. However, if the recipient's income is less than the amount of the personal allowance, the division shall pay to the recipient the difference between the amount of the personal allowance and the recipient's income. A reserve or an accumulated balance from such a source, together with other sources, may not be allowed to exceed the state's resource allowance allowed for adults eligible for state supplemental assistance or Medicaid as established by the rules of the office of Medicaid policy and planning.

(e) In addition to the amount that may be retained as a personal allowance under this section, an individual shall be allowed to retain an amount equal to the individual's state and local income tax liability. The amount that may be retained during a month may not exceed one-third (1/3) of the individual's state and local income tax liability for the calendar quarter in which that month occurs. This amount is exempt from income eligibility consideration by the division. The amount retained shall be used by the individual to pay any state or local income taxes owed.

(f) In addition to the amounts that may be retained under subsections (d) and (e), an eligible individual may retain a Holocaust victim's settlement payment. The payment is exempt from income eligibility consideration by the division.

(g) The rate of payment to the provider shall be determined in accordance with a prospective prenegotiated payment rate predicated on a reasonable cost related basis, with a growth of profit factor, as determined in accordance with generally accepted accounting principles and methods, and written standards and criteria, as established by the division. The division shall establish an administrative appeal procedure to be followed if rate disagreement occurs if the provider can demonstrate to the division the necessity of costs in excess of the allowed or authorized fee for the specific boarding or residential home. The amount may not exceed the maximum established under subsection (d).

(h) The personal allowance for one (1) month for an individual described in subsection (a) is the amount that an individual would be entitled to retain under subsection (d) plus an amount equal to one-half

(1/2) of the remainder of:

(1) gross earned income for that month; minus

(2) the sum of:

(A) sixteen dollars ($16); plus

(B) the amount withheld from the person's paycheck for that month for payment of state income tax, federal income tax, and the tax prescribed by the federal Insurance Contribution Act (26 U.S.C. 3101 et seq.); plus

(C) transportation expenses for that month; plus

(D) any mandatory expenses required by the employer as a condition of employment.

(i) An individual who, before September 1, 1983, has been admitted to a home or facility that provides residential care under this section is eligible for residential care in the home or facility.

(j) The director of the division may contract with the division of mental health and addiction or the division of disability and rehabilitative services to purchase services for individuals with a mental illness or a developmental disability by providing money to supplement the appropriation for community residential care programs established under IC 12-22-2 or community residential programs established under IC 12-11-1.1-1.

(k) A person with a mental illness may not be placed in a Christian Science facility listed and certified by the Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc., unless the facility is licensed under IC 16-28.

SECTION 8. IC 12-10-6-3, AS AMENDED BY P.L.1-2007, SECTION 117, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2008]: Sec. 3. (a) The division, in cooperation with:

(1) the state department of health taking into account licensure requirements under IC 16-28; and

(2) the division of mental health and addiction taking into account the licensure and certification requirements under IC 12-22-2;

shall adopt rules under IC 4-22-2 governing the reimbursement to facilities under section 2.1 of this chapter. The rules must be designed to determine the costs that must be incurred by efficiently and economically operated facilities in order to provide room, board, laundry, and other services, along with minimal administrative direction to individuals who receive residential care in the facilities under section 2.1 of this chapter.

(b) A rule adopted under ~~this~~ subsection **(a)** by:

(1) the division; or

(2) the state department of health;

must conform to the rules for residential care facilities that are licensed under IC 16-28.

~~(b)~~ **(c)** Any rate established under section 2.1 of this chapter may be appealed according to the procedures under IC 4-21.5.

~~(c)~~ **(d)** The division shall annually review each facility's rate using the following:

(1) Generally accepted accounting principles.

(2) The costs incurred by efficiently and economically operated facilities in order to provide care and services in conformity with quality and safety standards and applicable laws and rules.".

Page 2, line 5, delete "and".

Page 2, line 7, delete "." and insert "**; and**

(3) a biannual review of Medicaid waiver reimbursement rates.".

Page 2, line 24, delete "division, the office," and insert "division, ~~or~~ the office,".

Page 2, after line 30, begin a new paragraph and insert:

"SECTION 10. IC 12-10-7 IS REPEALED [EFFECTIVE JULY 1, 2008].

SECTION 11. [EFFECTIVE JULY 1, 2008] **(a) On July 1, 2008, all rules, contracts, assets, and liabilities of the division of aging's guardianship program under IC 12-10-7 (before its repeal by this act) are transferred to the division of disability and rehabilitative services under IC 12-9-7 (as added by this act) and are considered rules, contracts, assets, and liabilities of the division of disability and rehabilitative services.**

(b) This SECTION expires July 1, 2013.

SECTION 12. [EFFECTIVE JULY 1, 2008] **(a) This SECTION does not apply to the conversion of acute care beds to comprehensive care beds pursuant to IC 16-29-3.**

(b) As used in this SECTION, "comprehensive care bed" means a bed that:

(1) is licensed or is to be licensed under IC 16-28-2;

(2) functions as a bed licensed under IC 16-28-2; or

(3) is subject to IC 16-28.

The term does not include a comprehensive care bed that will be used solely to provide specialized services and that is subject to IC 16-29.

(c) As used in this SECTION, "replacement bed" means a comprehensive care bed that is relocated to a health facility that is

licensed or is to be licensed under IC 16-28. This term includes comprehensive care beds that are certified for participation in:

(1) the state Medicaid program; or

(2) both the state Medicaid program and federal Medicare program.

(d) Except as provided in subsection (e), the Indiana health facilities council may not recommend and the state department of health may not approve the certification of new or converted comprehensive care beds for participation in the state Medicaid program unless the statewide comprehensive care bed occupancy rate is more than ninety-five percent (95%), as calculated annually on January 1 by the state department of health.

(e) This SECTION does not apply to a health facility that:

(1) seeks a replacement bed exception under subsection (d);

(2) is licensed or is to be licensed under IC 16-28;

(3) applies to the state department of health to certify a comprehensive care bed for participation in the Medicaid program if the comprehensive care bed for which the health facility is seeking certification is a replacement bed for an existing comprehensive care bed;

(4) applies to the division of aging in the manner:

(A) described in subsection (e); and

(B) prescribed by the division; and

(5) meets the licensure, survey, and certification requirements of IC 16-28.

(f) An application described in subsection (e)(4) for a replacement bed exception must include the following:

(1) The total number and identification of the existing comprehensive care beds that the applicant requests be replaced by health facility location and by provider.

(2) A verification from the health facility holding the comprehensive care bed certification that the health facility has agreed to transfer the beds to the applicant health facility.

(3) A copy of the complete agreement between the health facility transferring the beds and the applicant health facility.

(4) Any other information requested by the division of aging that is necessary to evaluate the transaction.

(g) This SECTION expires June 30, 2011.".

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to SB 315 as reprinted January 29, 2008.)

BROWN C, Chair

Committee Vote: yeas 10, nays 1.

HOUSE MOTION

Mr. Speaker: I move that Engrossed Senate Bill 315 be amended to read as follows:

Page 4, delete lines 26 through 42.

Page 5, delete lines 1 through 5.

Page 5, line 39, delete "IC 12-22-2, IC 16-28," and insert "IC 16-28".

Page 7, line 33 delete ":".

Page 7, line 34, delete "(1)".

Page 7, line 34, after "health" insert ",".

Page 7, line 35, delete "; and" and insert ",".

Page 7, delete lines 36 through 38.

Page 7, run in lines 33 through 39.

Page 8, line 41, delete "biannual" and insert "**biennial**".

Page 9, line 34, delete "[EFFECTIVE JULY 1, 2008]" insert "[EFFECTIVE MARCH 31, 2008]".

Page 10, line 35, delete "A" and insert **"If the replacement bed is being transferred to a different health facility, a**".

Page 10, line 38, delete "A" and insert **"If the replacement bed is being transferred to a different health facility under different ownership, a**".

Page 10, after line 42, begin a new paragraph and insert:

"SECTION 14. **An emergency is declared for this act.**".

Renumber all SECTIONS consecutively.

(Reference is to ESB 315 as printed February 22, 2008.)

HOY